Special Article

Refer to: Myers BA, Leighton R: Medicaid and the mainstream: Reassessment in the context of the taxpayer revolt. West J Med 132:550-561, Jun 1980

Medicaid and the Mainstream: Reassessment in the Context of the Taxpayer Revolt

BEVERLEE A. MYERS, MPH, *and* RIGBY LEIGHTON, MS, *Sacramento, California*

California's Medicaid program—Medi-Cal—attempted to implement the ideal of mainstream medical care for the poor by giving program beneficiaries a "credit card" for use in the private health care marketplace. This exposed the program to the perverse economic incentives of the fee-for-service, cost-plus health care system, and contributed to a high rate of increase in program costs. Attempts to control costs have been equally perverse, resulting in low payment rates, the second-guessing of physician professional judgments, the probing of medical and fiscal records, and the use of computerized surveillance systems.

Attempts to shift to the use of more efficient delivery systems have had small success. Attempts to attain cost containment through restructuring the Medi-Cal program have been rejected in the name of the mainstream ideal. Costs have continued to escalate, with annual increases as high as 20 percent in some years. Medi-Cal now costs $4 billion per year, the largest single program in California state government.

The taxpayer revolt in California is creating a fiscal crisis that will force rethinking of the premises of publicly funded health care for the poor, and a restructuring of strategies for reaching that objective. In the short run, it appears that the issue may not be whether the indigent will have access to mainstream medical care, but whether they will have access to any *medical care. In the longer run, the crisis should represent an opportunity for building a system of health care that can serve the financially disadvantaged at a cost tolerable to our society.*

> "We can no longer afford a private, fee-for-service system of health care dependent solely on the good will of private providers."
>
> WESTERN CENTER ON LAW AND POVERTY LETTER TO GOVERNOR EDMUND G. BROWN JR. *December 12, 1978*

Ms. Myers is Director of the California Department of Health Services and Mr. Leighton is policy consultant of the California Department of Health Services.

Reprint requests to: Mr. Rigby Leighton, 455 Capitol Mall, Suite 250, Sacramento, CA 95814.

The Original Vision

THE FEDERAL PROGRAM of grants to states for medical assistance to the poor and disabled—now universally known as Medicaid—was brought into existence by the Social Security Amendments of 1965 (Public Law 89-97), along with the federally administered Medicare program. It represented a significant victory for those who be-

lieved that no person should be deprived access to necessary health care because of inability to pay. California was one of the first states to take advantage of the new federal grants; enabling legislation was passed in 1965 and the Medi-Cal program was implemented in March 1966.

The tenor of those times is captured well in this excerpt from a recently published interview with Paul Ward, currently President of the California Hospital Association, who in 1965 was Secretary of Health and Welfare in California:

Momentum developed in California for mainstream medical care, for the idea that everyone was entitled to high quality care. We even went so far as to say that the poor should have a credit card, much like the middle class. When they needed medical care, they would simply go to the hospital and show the card, get the care and go on about their way. We were ridiculed tremendously for that idea. So we drew back.[1]

Although there may have been a drawing back from the credit card approach in its pure form, it remained an essential principle of Medi-Cal (and Medicaid programs generally) that the objective was to permit the poor to buy into the mainstream of the health care system. Following is a key part of the Medi-Cal enabling legislation:

It is intended that whenever possible and feasible: (a) The means employed shall be such as to allow, to the extent practicable, eligible persons to secure health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability.[2]

Although conditioned by the phrases "whenever possible and feasible" and "to the extent practicable," the intent of mainstreaming is still clearly expressed in the phrase ". . . the same manner employed by the public generally."

The Price of the Vision

Thus, the basic operational principle for Medi-Cal was to give the program beneficiary a form of purchasing power in the private health care marketplace. The Medi-Cal identification card did become a type of credit card, although it soon became evident that controls would be needed in order to avoid bankruptcy of the program. Tables 1 and 2 illustrate the Medi-Cal cost issue in its simplest manifestation—the growth in number of eligibles covered by the program and the growth in the dollars expended.

According to Paul Ward, this growth rate was to be expected:

Nothing new is developing in the Medi-Cal program that wasn't predicted. If you go back to the original testimony given on the Medi-Cal program, Mark Berke who was then President of the California Hospital Association, predicted that the cost of medical care would reach 10 percent of the gross national product, and that we would see the day, with developing technology, of the $500 per day cost. Nobody believed him.[1]

For most observers, however, the rate of increase was much higher than expected. This in itself does not mean that the costs were inappropriate, of course, but there also occurred very early in the program the discoveries that (1) the price being paid was still not accomplishing the mainstreaming ideal and (2) a substantial amount of the money was being wasted because of fraud

TABLE 1.—*Growth in Number of Medi-Cal Eligibles**

Year	*Average No. of Eligibles Per Month*	*Percent Increase From Previous Year*	*Medi-Cal Eligibles as Percent of Calif. Population*
1966	1,181,000	..	6.3
1967	1,408,000	19.2	7.3
1968	1,541,000	9.4	7.9
1969	1,744,000	13.2	9.0
1970	2,174,000	24.7	10.9
1971	2,400,000	10.4	11.8
1972	2,312,000	(3.4)	11.3
1973	2,261,000	(2.2)	10.9
1974	2,345,000	3.7	11.2
1975	2,561,000	9.2	12.1
1976	2,679,000	5.3	12.5
1977	2,900,000	7.5	13.2
1978	2,904,000	0.1	13.0

*Source: Table 3 in Derzon RA, Celum CL: The Medi-Cal Program: Strategies for Constraining Costs in the Largest Single Expenditure in the State Budget. Health Policy Program, University of California, San Francisco, December 1979.

TABLE 2.—*Growth in Medi-Cal Expenditures*

Fiscal Year	*Total Medi-Cal Expenditures*		*Annual Expenditures Per Eligible*	*Medi-Cal General Fund Expenditures as Percent of Total State General Fund Expenditures*
	Amount (Millions of Dollars)	*Percent Increase From Previous Year*		
1966-67	$ 804	..	$ 681	8.4%
1967-68*	706	(12.2%)	501	6.4
1968-69	941	33.3	611	8.3
1969-70	1,119	18.9	642	8.8
1970-71†	1,257	12.3	578	10.1
1971-72‡	1,352	7.6	563	10.1
1972-73	1,444	6.8	625	10.0
1973-74	1,734	20.1	767	7.7
1974-75	1,996	15.1	851	8.4
1975-76	2,330	11.7	871	8.4
1976-77	2,653	19.0	984	9.2
1977-78	3,088	16.4	1,065	10.2
1978-79	3,405	10.3	1,173	11.5

*First Medi-Cal cost containment efforts (see text).
†Stronger prior authorization imposed for hospital inpatient care; schedule of maximum allowances for hospital outpatient services; review teams for long term care.
‡Provisions of Medi-Cal Reform Act of 1971 begin to take effect.
Source: Tables 1, 2, and 3 in Derzon RA, Celum CL: The Medi-Cal Program: Strategies for Constraining Costs in the Largest Single Expenditure in the State Budget. Health Policy Program, University of California, San Francisco, December 1979.

and abuse by providers and recipients. Following are excerpts from a report on Medi-Cal prepared in December 1968 by Henry Anderson, a research assistant with the Department of Public Health:

> This laudable concept [patient freedom of choice of providers] is not being well served by Medicaid, in actual practice. In many cases, recipients have scarcely more freedom of choice than they did in the days when they had to go to the outpatient department of the county hospital. A new equivalent of the county hospital has sprung up in the "private sector"—the ghetto physician who enjoys a monopoly in his particular neighborhood. Patients wait in his outer office for hours, just as they used to in the county hospital; they receive care which is every bit as impersonal, and not as good technically as that rendered by the average intern or resident in a county hospital.
>
> In the Surveillance Unit, we consistently found that about 5 percent of the practicing physicians in the state were providing nearly half of all the services in the Medi-Cal program. On the other hand, approximately 50 percent of all the physicians in the state, at the other end of the utilization spectrum, were providing fewer than 5 percent of all the services under the program. Furthermore, in studying the backgrounds of these two groups of physicians, we were struck by an inescapable conclusion: the 5 percent who provided close to a majority of all the care in the program tended to be marginal or submarginal.[3]

Anderson also reported that the Surveillance Unit had identified hundreds of providers who were apparent abusers of the program, based on examination of paid claims data. Even though the Unit had resources to examine only the most extreme cases, Anderson stated that ". . . curbing the abuses we felt we had identified in 1 percent or 2 percent of vendors would have saved the program between $25,000,000 and $50,000,000," which represented 4 percent to 8 percent of the Medi-Cal budget at that time.

We should clarify, as did Anderson in his report, that we believe only a small percentage of providers (or beneficiaries) to be sources of fraud and abuse. The fact remains, however, that the public view of ethics among health professionals has been considerably modified by disclosures of provider behavior in the Medicaid and Medicare programs. There is understandable legislative reluctance to invest more public dollars in these programs until there can be assurance that fraud and abuse are under control. This is fueled by recent allegations that the cost of fraud and abuse is much higher than the 4 percent to 8 percent estimated by Anderson. California's Little Hoover Commission (Commission on California State Government Organization and Economy) has estimated that the figure could be as high as 20 percent (written communication to Governor Edmund G. Brown Jr., et al, September 10, 1979); a recent article in the *LACMA Physician,* by Edward Zalta, MD, concurs with that estimate.[4] There is no evidentiary base for these higher estimates, but they nevertheless represent an increasingly common view of reality.

The Inherent Cost of the Mainstream System

More important than fraud and abuse, in the judgment of the authors, is the fact that under the mainstream ethos the Medi-Cal program buys into the inefficiencies inherent in this country's health care system. The high rate of inflation in the cost of health care generally over the last few years has given medical economists ample opportunity to point out the flaws in that system, as exemplified by the following quotation from Stanford economist Alain Enthoven:

> The main cause of unnecessary and unjustified increase in costs is the complex of perverse incentives inherent in our dominant financing system for health care: fee-for-service for the doctor, cost-reimbursement for the hospital, and third-party insurance to protect consumers, with premiums usually paid entirely or largely by employers or government. This system rewards providers of care with more revenue for giving more and more costly care, whether or not more is necessary or beneficial to the patient. It leaves insured consumers with little or no incentive to seek a less costly health care financing or delivery plan.[5]

In this statement, Enthoven is not talking about Medicaid programs per se, but it clearly applies to Medicaid simply by replacing his phrase "insured consumers" with the phrase "Medicaid beneficiaries." The high rate of increase in Medicaid program costs was to be expected, the economist would say, because demand is unconstrained by the "natural" control of out-of-pocket cost to the consumer. Nor is there any incentive in the system for providers to act in the interest of efficiency; indeed, the efficient provider may simply be losing revenue to inefficient colleagues.

Government Response to Medicaid Costs

The first cost crisis with Medi-Cal occurred when the program was scarcely a year old, and there immediately was a state response that by now represents a very familiar pattern. In August 1967 the state announced emergency regulations to restrict Medi-Cal benefits sharply, citing a projected cost overrun of $210 million for the 1967-68 fiscal year (which at the time represented about 30 percent of the budget). The regulations called for the elimination of certain benefits—for example, chiropractic services, psy-

chiatric services and audiologist services. Other services were restricted: for other than county hospitals, hospital stays were limited to eight days without prior authorization; physician fees were frozen; nonemergency surgical operations were eliminated; optometrists were limited to eye refractions following lens extraction; routine care of nails, corns and calluses was eliminated, and so forth.

The issuance of these emergency regulations was greeted immediately with a temporary restraining order from the Superior Court in Sacramento. Most of the regulations were set aside by a Supreme Court ruling a few months later, but the restrictions on length of hospital stays and physician fees were allowed to stand. Thus, another Medi-Cal tradition was initiated—the use of the courts to decide issues of program administration.

As the cost of Medi-Cal and other Medicaid programs continued to grow at rates in the neighborhood of 15 percent to 18 percent per year, a great many cost containment strategies were attempted. A recent analysis[6] prepared for the California Department of Health Services catalogues approximately 130 cost containment concepts that are either being used in Medicaid programs or have been recommended for use. This variety is obviously too great to discuss in detail in this article, but we can examine the major themes. Table 3 presents a simple taxonomy of Medicaid cost containment approaches. The first level of subdivision separates the concepts that are internal to the Medicaid program—that is, those that can be accomplished by altering the policies and operation of the program itself—from those that are external, in the sense of being dependent on more global modifications in the health care system itself. For cost containment approaches internal to a Medicaid program, there is again a bipartite subdivision: The concepts refer either to reducing the scope of the program or increasing its efficiency.

Reducing the scope of a Medicaid program may mean either reducing the number of people eligible for the program benefits, through modification of the eligibility criteria; or it may mean restricting the benefits available to those who are eligible.

Increasing the efficiency of a Medicaid program means reducing the number of dollars necessary to provide a given scope of benefits to a given population. As indicated by the table, cost containment concepts in this area generally relate to either reducing the need for care among the eligible population, reducing rates of payment, implementing administrative interventions to avoid (either prospectively or retrospectively) inap-

TABLE 3.—*Taxonomy of Medicaid Cost Containment Concepts*

Concept Category	*Examples*
I. Internal—can be implemented within the program	
A. Reduction in scope of program	
1. Reduce number of eligibles	Eliminate optional aid categories. Increase beneficiary share of cost. Require work registration as condition of eligibility.
2. Reduce scope of benefits	Remove outpatient psychiatric services. Limit acute hospital inpatient days to 21 per beneficiary per year.
B. Increase program efficiency	
1. Constrain provider rates	Freeze physician payment rates. For selected surgical procedures, pay outpatient rate only.
2. Reduce need for care	Implement program of secondary prevention such as hypertension control.
3. Administrative interventions	Require prior authorization. Implement automated surveillance system. Use detailed edits and audits during claims processing.
4. Alternative delivery systems	Contract with HMO's. Contract selectively with hospitals, choosing efficient facilities.
II. External—require changes in health care system generally	
A. Develop more efficient health care delivery system	Encourage development of HMO's. Implement "consumer choice" economic theory.
B. Reduce poverty	Job training programs.
C. Reduce illness	Free family planning for low income persons. Traditional public health measures.
D. Spread actuarial risk	Require broader and longer coverage with employer policies. Implement subsidized health insurance for low income persons.

TABLE 4.—*Distribution of Medi-Cal Costs by Category Eligibility*

Eligibility Category	*Percent of Health Care Costs*
Public Assistance categories	
1. Aid to Families with Dependent Children	22.4
2. Disabled	25.1
3. Aged	21.8
4. Blind	0.7
Medically Needy (categorically linked)	
5. Aid to Families with Dependent Children	6.0
6. Disabled	2.1
7. Aged	2.1
8. Blind	0.0
Medically Indigent (not categorically linked)	
9. Medically Indigent Children	3.7
10. Medically Indigent Adults	17.4

Note: The Medically Needy categories (lines 5-8) and Medically Indigent Children (line 9) are optional categories under federal law. Federal financial participation (FFP) is available if a state elects to invest in coverage of these categories. The Medically Indigent Adult category (line 10) is not covered by the federal Medicaid law; all costs are paid by the state of California.

propriate costs or attempting to shift to alternative health care delivery systems that in themselves are believed to be more efficient.

The shift to more efficient delivery systems is also an external strategy, under the reasoning that Medicaid will benefit from such developments as increasing the number of health maintenance organizations. The other cost containment approaches that would be classified as external to the Medicaid program are generally aimed at preventing people from developing the need for the program's benefits. Since people become eligible for a Medicaid program by being either poor, or marginally poor and sick, these concepts fall readily into the three classses of attempting to increase the health status of the general population, reducing the likelihood of poverty and using alternatives to tax funding for spreading among the working population the fiscal risk of illness among the marginally poor.

Cost Containment Through Reducing Program Scope

In the remaining discussion we will restrict our attention to the cost containment concepts internal to Medicaid programs, leaving for other forums the consideration of global modifications in the country's health care system or economic system (or both). We first consider program cost reduction through restrictions in scope—eligibles or benefits.

Table 4 shows how the health care expenditures in the Medi-Cal program are distributed among categories of eligibility. Note that the Medi-Cal eligible population is really a set of subpopulations that differ from one another demographically and in terms of health care need. Every Medicaid program must cover persons who are receiving cash grants under either a state Aid to Families with Dependent Children (AFDC) program or the Federal Supplemental Security Income program for the aged, blind and disabled. States may elect to go beyond these mandatory categories to extend Medicaid eligibility to the medically needy—persons who meet the categorical criteria (families with dependent children, and the aged, blind or disabled) but who have income above the cash grant limit. (Persons with income more than 33⅓ percent above the cash grant limit can only become eligible by spending the excess income on health care—a process commonly known as "spending down.") The federal medically needy eligibility criteria also include persons under 21 and families which do not meet AFDC criteria, but do meet the other medically needy income level criteria.

A very potent form of cost containment for a state is simply to eliminate all of the eligibility categories not absolutely required by federal law. California has in the Medi-Cal program the broadest scope of eligibility permitted by federal law; indeed, Medi-Cal includes a Medically Indigent Adult eligibility category which goes beyond the federal limits, and consequently receives no federal financial participation. California could save approximately 41 percent of Medi-Cal costs to the state general fund simply by eliminating the eligibility categories that are optional according to federal standards.

The temptation to do this has been resisted throughout the history of the Medi-Cal program, in spite of strong cost containment pressures. The major reason is that this form of cost containment simply means shifting the burden of indigent health care to other levels—county or city governments, providers or individual patients. Moreover, this affects those who are medically indigent —meaning both poor and sick, the persons most in need of medical assistance. Such a change would contradict the essential mission of a Medicaid program, which is to assure that limited financial resources are not a barrier to obtaining necessary health care.

The other approach to reducing Medicaid costs by reducing scope is through restriction of benefits. Table 5 shows how the Medi-Cal health care

TABLE 5.—*Medi-Cal Costs by Category of Service, Fiscal 1978-79*

Category of Service	*Percent of Health Care Costs*
1. Hospital inpatient	38.4
2. SNF and ICF	20.8
3. Physician	17.1
4. Outpatient clinics	5.7
5. Prescription drugs*	5.5
6. Dental*	3.7
7. Professional, other than physician*	3.7
8. Short-Doyle*	2.9
9. Other*	2.1

*Most of the services included in these categories represent services not required of a state Medicaid program by federal law, but services in which there will be federal financial participation if offered by the state. Most of the services covered in the categories in lines 1-4 are mandated by federal law for any state that operates a Medicaid program.

SNF = skilled nursing facility
ICF = intermediate care facility

dollar is distributed among categories of service. Again, federal law requires that the Medicaid program offer certain types of health care service, with others available at state option. An obvious cost reduction alternative for a state with more than the federally mandated services, as California has, is to eliminate the optional services. Table 5 shows that this would reduce the Medi-Cal cost by approximately 15 percent. However, a third of that 15 percent represents outpatient pharmaceuticals. Even though this is optional by federal standards, it would be unwise to eliminate it from the program, since there would undoubtedly be a shift to use of higher-cost modalities of treatment.

States may also place limits on the extent to which mandatory services are covered. For example, the Oregon Medicaid program presently covers only 15 days of acute inpatient hospital care per year for each beneficiary. This is an approach that has been resisted in the more liberal Medicaid programs because it has exactly the same effect as restricting eligibility—the people most in need of medical assistance are the ones who are cut off when their benefits are exhausted. The financial burden for their care is simply shifted from the state level (where there is federal financial participation) to either local government, private sector charity or the individual person.

Cost Containment Through Increasing Program Efficiency

Since cost containment by reducing the scope of a Medicaid program is inimical to its fundamental purpose—providing necessary health services to those who cannot afford them—considerably more emphasis has been placed on attempts to make the Medicaid program more efficient.* In this context, increasing efficiency means reducing the number of dollars needed to provide a specified scope of benefits to a beneficiary population of specified size and eligibility category mix.

In considering the "efficiency" approaches to cost containment, it is especially important to note that the nature of government reaction to the escalating costs of Medicaid programs has been keyed directly to the nature of the "mainstream" health care system. In particular, the government cost controls are largely determined by the reimbursement methods that the majority of providers insist upon.

For example, when Medicaid was originated, the hospital industry successfully lobbied for "reasonable cost" reimbursement as a federal requirement for inpatient care. Given this as the essential reimbursement method, when a Medicaid program is faced with limited financial resources, it is both rational and inevitable that the following cost control measures will be taken with respect to hospital inpatient care:

- Prior authorization of access to hospital inpatient care, which is the most expensive type of service in a Medicaid program. As noted above, this was begun in Medi-Cal in 1968 (for stays beyond eight days in noncounty hospitals). It was made more stringent in 1970, by requiring prior authorization for all nonemergency hospital admissions and emergency hospital stays beyond three days.
- Limitations on length of hospital stays without additional authorization. This was started in Medi-Cal in 1970, and now is a common element of the "concurrent review" conducted by Professional Standards Review Organizations across the country.
- Careful scrutiny of cost accounting methods, and the method of allocating total hospital costs to the Medicaid patients.
- Reinterpretation of "reasonable cost" to mean reasonable *amount* of cost as well as reasonable type of cost. This means judging reasonableness in terms of costs in similar institutions, and increases in "input" costs for the hospital in-

*It should also be noted that those states that have Medicaid programs of limited eligibility and benefits still tend to experience the same rate of increase in costs as the more liberal programs, even though the dollars expended per beneficiary will be less. The motivation to increase program efficiency is thus as strong in the restricted programs as in the liberal ones.

dustry; and evaluating medical necessity as an element of reasonableness. For selected hospitals, Medi-Cal now sends in multidisciplinary teams for the retrospective audits, which include medical personnel as well as fiscal auditors.

- Attempts to limit participation to efficient facilities. In 1979 the administrators of Medi-Cal prepared a legislative initiative—subsequently defeated through the strong opposition of the industry—to obtain authority to contract selectively with hospitals.

Most physicians prefer to be reimbursed on the basis of usual and customary fees for each service rendered. Under federal regulations, Medicaid programs have more freedom to restrict physician payment levels than they do hospitals for inpatient care—the major constraint is that states cannot pay physicians more than they receive from Medicare. Under cost containment pressure, then, it is to be expected that states will take the following actions:

- Reduce physician fees, or freeze them over long periods of time in spite of general inflation. As noted above, this was part of the Medi-Cal reaction to the first cost crisis, in 1968. Medi-Cal rates for physicians presently average about 55 percent of usual and customary charges.

- Implement sophisticated computer systems to catch physicians who attempt to compensate for the low fees by bringing patients back for multiple visits, performing (or at least billing for) injections and laboratory tests on each visit, or similar inventive techniques for maintaining revenue. Anderson had this capability back in 1967 and 1968; it is now a part of the "Surveillance and Utilization Review" system for which the federal government pays states a bonus to implement.

- Introduce computerized edits into the invoice processing system itself, which are intended to apply a degree of medical judgment to each service billed by a physician. The contemporary automated invoice processing systems used in Medicaid programs, for example, will check on whether the procedure billed was justified by the diagnosis; whether the procedure was appropriate for the age and sex of the patient; whether the frequency of the procedure was appropriate. Some of these edits are mundane and obvious—such as no more than one appendectomy per patient; others may be more judgmental—such as no hysterectomies in women under age 25. (The computer does not make final judgments on these matters. Instead, claims are referred to medical personnel for review.)

- Send state-employed investigators into physician offices, in the guise of Medicaid beneficiaries, as the ultimate check on physicians suspected of fraud or abuse. This has not yet happened in California, primarily because state law does not permit it, but has been done in other states.

This last statement illustrates the extreme we have reached in Medicaid programs, as government and providers each try to compensate for the behavior of the other. The authors largely agree with Dr. Zalta, a strong critic of Medi-Cal, when he states the following with respect to fraud and abuse:

> The present system has spawned this and continues to nurture it. Inadequate reimbursements and higher litigation rates make it more difficult for hospitals and physicians to accept the Medi-Cal patient. The deserving poor are thus forced into a "mill" where manipulators milk the system for all its worth.
>
> Even some honest practitioners delude themselves into "rationalizing" fraudulent behavior by adding on extra services. These practitioners have had so many legitimate claims rejected by the state that they feel justified in "beating the system."[4]

We conclude that if the fee-for-service, cost-plus system has inherent perverse economic incentives, as Enthoven claims, the attempts by government to control Medicaid costs have been equally perverse. States have developed extensive procedures for second-guessing the professional judgments of physicians, and for probing the fiscal and medical records of physicians, hospitals and other providers. These invasive techniques, together with low payment levels, drive physicians out of the program, reduce beneficiary access to physician care, and force beneficiaries into use of hospital emergency rooms—usually in county hospitals, the provider of last resort. Quality suffers, costs continue to increase, and the state in turn invents new ways to intervene in the health care process. This could hardly be the vision of mainstream medicine that stimulated the creation of Medicaid.

The Search for Alternative Systems

It was to be expected, then, that government would seek alternatives to the fee-for-service, cost-plus system as the method of health care delivery for Medicaid. After all, for many years in California there have been millions of people

receiving care through organized delivery systems such as Kaiser Health Plan and Ross-Loos, at considerable saving over the usual indemnity insurance plans.

Medi-Cal first experimented ,with prepaid health care in 1968. By 1971 the policy decision had been made that the best solution to cost containment would be contracts with prepaid health plans (PHP's). The Medi-Cal Reform Act of 1971 laid the foundation for a carrot-and-stick approach to increasing the reliance on PHP contracts. The "stick" was the implementation of more stringent prior authorization and service limitation controls on fee-for-service Medi-Cal—the types of controls we have just discussed. The "carrot" was the easing of certain legal barriers to PHP contracting, plus aggressive administrative action to encourage contract proposals.

The following quotation from a staff policy paper of 1972 communicates the enthusiasm with which this new alternative was pursued:

> A decision has been reached in California public policy —*Prepayment in the delivery of health care offers the best solution to the joint problem of cost control and quality of care.* [Emphasis in original.]
>
> And most significantly, prepayment to providers, whether they are aware of it or not, offers a means for them to retain control of their fiscal and professional destinies, to bring about modern management and organization in the delivery of care, and to foster the kind of care that is most meaningful to the true health and well being of California's people. . . . the change now happening in California is not a minor event but an avalanche which will find echoes and parallels across the nation.[7]

We know now, of course, that there were flaws in the PHP theory. Just as at the inception of Medicaid few people had anticipated such phenomena as "Medicaid mills," so at the inception of the PHP program few people expected the degree of abuse that resulted from stimulating entrepreneurial instincts through prepaid contracts. The financial incentive of such contracts is to sign up as many healthy Medi-Cal beneficiaries as possible, and then to minimize costs by minimizing service levels. It had been expected that this incentive would be largely offset by professional ethics, together with a modest amount of state monitoring, but experience soon showed that prepaid care was as much susceptible to abuse as fee-for-service care. And because beneficiaries were "locked-in" to a single source of care, the impact of such abuse was specially adverse.

It is still not clear the extent to which the problems of the PHP program were specific to a few notorious contractors, or were spread through much of the program. What *is* clear is that the state had insufficient monitoring capability to discern where the real problems lay—beyond the obvious scandals—and to satisfy the public that they could be controlled. This has been rectified (at least to the extent that there have been no major scandals for the last four years), through administrative action and new legislative requirements at both the state and federal levels.

It is easy, because of the scandals in the early years of California's PHP program, to overlook the inherent advantages to both providers and the state in this form of health care delivery. These are the following:

- Efficiency. The evidence from a variety of settings is that PHP's can provide a comprehensive spectrum of benefits at costs ranging from 10 percent to 40 percent less than the fee-for-service system.[8] For Medi-Cal itself, the savings have averaged about 15 percent (Rigby Leighton, "Evidence for Cost Reduction Impact of PHP Contracts," internal memorandum, California Department of Health Services, April 5, 1978). The Michigan Medicaid program, which now has a higher percentage of its beneficiaries under prepaid contracts than any other state, reports savings on the order of 15 percent to 20 percent. There is no other single cost containment technique which can produce this degree of saving in a Medicaid program, short of severe restrictions on eligibility.

- Professional autonomy. The major advantage from the provider perspective is freedom from the controls applied to fee-for-service: prior authorization, computerized edits applied to each service rendered, and the retrospective "surveillance and utilization review" of patterns of service rendered. There are requirements for internal quality assurance procedures, and periodic medical audits are conducted to assure that such procedures are effective, but these are oriented toward the total system of health care rather than the second-guessing of individual judgments that occurs wth fee-for-service claims.

- Legal obligation to serve beneficiaries. From the beneficiary perspective, the major advantage is guaranteed access. Unlike fee-for-service providers, the PHP contractor takes on a legal obligation to serve those beneficiaries who elect to enroll. The early PHP program experience made

it clear that there needs to be monitoring to assure that this obligation is satisfied, but there is not even the basis for such monitoring with fee-for-service physicians.

There are numerous other advantages that could be attributed to PHP's, under the same theory that is held by many to apply to Health Maintenance Organizations: incentive for preventive medicine, improved case management through centralized record-keeping and the like. These putative advantages are more arguable than the three cited above, however, which are sufficient in themselves to account for the survival of the California PHP program in spite of its early scandals, and the current federal emphasis on encouraging the spread of Health Maintenance Organizations.

The Freedom of Choice Dilemma

Even though the PHP program was a conscious attempt to move away from the fee-for-service, cost-plus system, it still could be construed as a mainstream option. Prepaid care is certainly a well-established option in California—currently about 20 percent of the people not covered by Medi-Cal or Medicare belong to Health Maintenance Organizations. Also, the program did not deprive Medi-Cal beneficiaries of the freedom to choose a fee-for-service identification card.

However, the PHP program obviously did not meet the cost containment objectives of its founders, who had anticipated that within a few years most beneficiaries would be covered under such contracts. A Medi-Cal policy paper developed in 1974, titled "The Medi-Cal Program, A New Direction," analyzed the problem this way:

> Although 56 individual PHP's are operating in California today, the expansion of this concept statewide has been hindered by the competitive environment and the stringent marketing procedures necessitated by the federal "freedom of choice" requirements. As a result the vast majority of beneficiaries continue to receive their medical care via the conventional fee-for-service system.[9]

(The policy paper failed to note the adverse influence of active campaigns by welfare rights advocates and eligibility workers to keep beneficiaries out of PHP's, and the legislative and congressional investigations of the program.)

The "New Direction" paper proposed to overcome these obstacles by contracting with a single Organized Health Delivery System (OHDS) in each geographical area. To the extent possible, the OHDS selected would have the capability of providing all medical services from a centrally located facility. Reimbursement would be through either prepaid capitation in the manner of PHP's (the preferred alternative) or prospective budget approval.

In terms of policy, the most significant aspect of the proposal was the abandonment of beneficiary freedom of choice, one of the cornerstones of the mainstream medicine ideal. The proposal stated "Each beneficiary within a designated area would be assigned to the selected organization for all his health needs." This recommendation was justified with the following two arguments:

- Beneficiary welfare.

The availability of routine and emergency care would be guaranteed to each beneficiary. Currently, due to the increasing specialization, a beneficiary is often referred to several providers, often at diverse locations, for the treatment of his illness. A centrally located facility would have all specialties available, thereby eliminating both costly referrals and duplication of effort. The OHDS concept would permit consolidation of a beneficiary's medical records, the development of beneficiary medical profiles, and assure continuity of care.

- Economic necessity.

The OHDS concept appears to be the only viable alternative to massive tax increases which will be necessary to continue the present fee-for-service system.

The "New Direction" paper estimated that the OHDS concept could reduce Medi-Cal expenditures by 20 percent.

The OHDS concept never became official Department policy. Indeed, it was completely rejected by the Health Department leaders who came into office with the new Brown administration in 1975.* Rather than allowing cost containment to be the dominant theme, the new administration removed many of the prior authorization controls in fee-for-service Medi-Cal and launched an extensive reformation of the PHP program. The number of PHP contractors was cut in half by the end of 1975, and halved again by the end of 1976.

Medi-Cal costs increased by 12 percent between fiscal 1974-75 and 1975-76, and 19 percent between 1975-76 and 1976-77. Yet "massive tax increases" were not necessary; indeed, the state enjoyed a multibillion dollar surplus. At this point, the OHDS concept paper—the first explicit critique of the practicality of mainstream medicine for Medi-Cal—seemed to represent little

*The concept is by no means dead, however. The state of Arizona recently announced a cost containment strategy for its indigent medical care program, based on assignment of beneficiaries to either HMO's or an individual primary care physician.[10]

more than self-serving hyperbole when it asserted that "At some point the taxpayer either cannot or will not bear the awesome increases in the existing Medi-Cal program." This statement was to be prophetic, as we will discuss presently.

The Taxpayer Revolt

Publicly funded health care was not the explicit target of the California taxpayer revolt that began with Proposition 13, but it has been, and will continue to be, a victim. The immediate impact of Proposition 13 itself, which passed in June 1978, was to reduce property tax revenue to counties. This in turn sharply reduced the ability of counties to operate health facilities (about 30 percent of Medi-Cal hospital inpatient and outpatient care was in county facilities), to meet their legal obligation for health care of the indigent not eligible for Medi-Cal, and to meet the "county share" obligation for Medi-Cal program costs. Prior to Proposition 13, the counties had been contributing approximately 12 percent of the Medi-Cal budget.

The immediate fiscal impact of Proposition 13 on the counties was resolved by using surplus state funds to supplement lost property tax revenue. The county share of Medi-Cal cost was eliminated and counties were given state funds to support both public health services and personal health services to the indigent. For the moment, publicly funded health care was impaired, but not disastrously so.

A secondary effect of Proposition 13 was the attempt of politicians to respond to its "message." All agencies of California government were asked to propose 10 percent budget cuts for the 1979-80 fiscal year. Since the Medi-Cal program budget had been growing at an average annual rate of 15 percent per year, the request for a 10 percent *cut* was in effect a requirement for an immediate 25 percent cost containment effect.

Beverlee Myers, Director of the Department of Health Services, convinced the Governor that Medi-Cal should not be subjected to an immediate 10 percent cut; that instead, a plan for restructuring the Medi-Cal program would be developed with the objective of producing a long-range 10 percent cost containment effect. The Medi-Cal Restructuring Plan of 1979 was developed,[11] with the following elements:

- Increased reliance on prepaid health plans and other forms of organized health systems (but not the franchising envisioned by the 1974 OHDS proposal, and without removing of beneficiary freedom of choice).
- Special contract relationships with county health systems, with particular emphasis on stimulating county-operated PHP's.
- Requiring beneficiaries to make an explicit, informed choice of method of receiving benefits (PHP, fee-for-service, county system and so forth) at time of eligibility determination.
- The development of contracts with high-volume providers, including risk-sharing and other incentives to efficiency.
- Selective contracting with hospitals for inpatient care, to minimize the program's exposure of the cost of the excess hospital capacity which is prevalent in California.
- Strengthening of fee-for-service controls, but without return to the service limitations imposed pursuant to the Medi-Cal Reform Act of 1971.

The Restructuring Plan represented a clear intent to move away from almost exclusive reliance on the fee-for-service, cost-plus system toward (1) more extensive use of organized health systems and (2) a system of contracting with providers that would allow the Department to emulate the functions of organized health systems. Beneficiary freedom of choice would be preserved, but the hope was to provide beneficiaries with more efficient options for receiving Medi-Cal benefits than was represented by fee-for-service.

The legislative proposal necessary to implement many features of the Restructuring Plan, introduced as Senate Bill 716, was strongly opposed by the hospital and medical industry. The principal argument used against the bill was that it would do away with mainstream medical care for the poor. Following is an excerpt from the statement of Paul Ward, writing as President of the California Hospital Association (CHA):

> CHA opposes SB 716 because it will result in a return to the separate system of care for the poor that existed prior to 1965—a system that was underfunded, overcrowded and inadequately supported to meet the health needs of the poor. The legislature decided in 1965 that there should not be a separate system for the poor, that the poor should have access to the same care provided the remainder of our society and we trust that this legislature will not want to return to the dual system of the past. (Written communication to the Honorable John Garamendi, Chairman, Senate Commission on Health and Welfare, April 2, 1979.)

The California Medical Association (CMA) had a similar viewpoint:

Medi-Cal beneficiaries will be forced to return to something similar to the county hospital system, an institution of the past notorious for its poor quality of care provided to indigents. . . . The anonymity suggested by the county health care system could severely hinder and possibly eliminate the trust and confidence of the established physician-patient relationship now available to the Medi-Cal recipient through the fee-for-service system. (Written communication from George F. Cate, Associate Director, Division of Government Relations, California Medical Association, to members of the Senate Health and Welfare Committee, May 22, 1979.)

It is clear that CHA and CMA still considered mainstream health care a feasible objective for Medi-Cal. Indeed, the CMA statement seems to imply that it is "now available to the Medi-Cal recipient through the fee-for-service system." CHA did not offer an alternative plan for Medi-Cal cost containment. CMA did support,[12] as its cost containment alternative to SB 716, a bill that had as one of its provisions the raising of Medi-Cal physician payment rates to Medicare levels. That would have been a 45 percent increase in physician reimbursement, adding $400 million per year to Medi-Cal costs.

SB 716 was defeated, thus meeting the same fate as all recent California legislation aimed at containing health care costs. The Department continues to pursue the elements of the Medi-Cal restructuring strategy, to the extent they are enabled under existing statute, which is primarily under limited pilot project authority.

The Coming Crisis

California's Proposition 13 proved to be only the first round in the taxpayer revolt. It was emulated in variations in several other states, either through voter initiatives or legislative action to preclude voter initiatives. In November 1979 the California electorate passed Proposition 4, the Gann Initiative, setting an annual increase limit on government appropriations. The June 1980 California ballot carried Proposition 9—which was commonly known as either "Jarvis II" in reference to its sponsor or "Jaws II" in reference to the impact it would have had on state revenue from personal income taxes.

Although Jarvis II failed to pass, the prospect of its passage was taken seriously by California state government. In anticipation of the worst, all state agencies were requested to prepare contingency budgets with 30 percent fewer dollars in them than the fiscal 1980-81 budget then before the legislature.

The failure of Jarvis II brought temporary relief, but it is clear that the fiscal stress on Medi-Cal can only become stronger in the next few months and years. The safest prediction to make about the types of cost containment strategy that will be pursued is this one: All of the above. If Medi-Cal is indeed expected to live on significantly fewer dollars than it has in the past, then all alternatives must be considered.

Note that the most extreme proposal advanced thus far for increasing the efficiency of the program—the organized health delivery system proposal of 1974, which would have removed beneficiary freedom of choice—was estimated to save 20 percent, and that was very likely an optimistic estimate. If Jarvis II is indicative of the degree to which tax revenues may be reduced in the future, either through subsequent voter initiatives or legislative action to forestall such initiatives, then it will be necessary to reduce the scope of the Medi-Cal program, by cutting eligibles or benefits (or both).

The dilemma this presents for California is that the counties, although legally the providers of the last resort, are ill-prepared to take up the slack, because of the impact of Proposition 13. The counties are already receiving a state subsidy averaging more than 40 percent of their costs for both public health programs and personal health care of the indigent not presently eligible for Medi-Cal, and that subsidy itself will be in jeopardy if there is substantial reduction in health care expenditures.

Reassessing the Mainstream Ethic

In the Paul Ward interview we have quoted above, Mr. Ward was asked whether he still felt the ideal of mainstream medicine for the poor was realistic. His answer was not explicit, but it was pessimistic:

It's a change of attitude. It is said that the life of an issue in American politics is seven years. Health ran its course as an acceptable issue; people became bored with it and tired of it. Their interests turned to other issues: environment, energy. So they said, "We're going to have to put the brake on health expenditures."[1]

At the outset of this article we quoted a letter from the Western Center on Law and Poverty to Governor Brown (December 12, 1978), which put the matter plainly: "We can no longer afford a private, fee-for-service system." This may sound like a typical right-wing, antiwelfare statement, but in fact the letter was signed by 45 representatives of local legal aid societies, who are among

the strongest advocates for the rights of the poor. The letter was sent in protest of the Governor's request, following the passage of Proposition 13, that a plan be developed to cut the Medi-Cal budget by 10 percent. The message of the letter was that county health services, the providers of last resort for the poor, must be sustained: ". . . It is obvious that further cuts in health care and a failure to assist county health care systems with State funds will mean more suffering, maiming and death."

The significance of the Western Center statement is that it signals recognition, by those most concerned with the plight of the disadvantaged, that simplistic adherence to the "mainstream medicine" principle is unworkable under current cost containment pressures. These advocates for the poor see the fundamental issue as not whether the poor will have access to mainstream care, but whether the poor will have access to *any* care.

There seems little doubt that we are facing a time when it is not only opportune, but absolutely necessary, to rethink our ideals and our strategies. There is no need to abandon the objective of providing all persons an equitable opportunity for good health, regardless of financial status. But we do need to be prepared to abandon our shibboleths in the interest of finding a more realistic way to reach that objective.

This is not a new concept. Anderson saw it clearly in 1968, when he concluded a discussion of the fallacy of the mainstream ideal with the following observation:

> The proper standard for evaluating public medical care programs is not what was done at some other time, or is being done at some other place, but what it is possible to do here and now, given the amount of money we have to spend and given what we know about the art and science of preventing disease, curing it and prolonging life. Or, to put it another way, the most fitting goals and yardsticks of the programs are not extrinsic but intrinsic: what is happening to the people being served by these programs.[3]

Summary

The credit card approach to funding health care for the poor carried with it the economic seeds of its own destruction, exacerbated by the incentives of the reimbursements demanded by most health care providers. We have allowed an unthinking preoccupation with mainstream medical care as a philosophical ideal to distract us from the more fundamental task of building a system of health care that can serve the financially disadvantaged at a cost tolerable to our society.

Publicly funded health care is facing a growing economic crisis because of the taxpayer revolt, but publicly funded health care had a part to play in stimulating that revolt. Although the fiscal impact cannot be predicted with certainty, it is highly likely that a wide variety of cost containment strategies—including those that have thus far been unpleasantly invasive of the professional functions of physicians and other health care providers—will be called into play in an effort to maintain the integrity of these programs. A time of crisis is also a time of opportunity. In the 15 years of the Medicaid program history we have learned some hard lessons in medical economics, ethics, and politics. We have a considerable amount of experiential data with which to rethink our premises and restructure our strategies.

Our rethinking must center on the fact that resources are limited. Rationing of health care is not avoidable; the issue is how and by whom it will be accomplished. This is not to say that the health care industry should not fight for its share of society's resources, particularly in the interest of the disadvantaged. But it would be foolish to base our program's operational strategies on pious philosophies that would require unlimited supply to implement. This is the lesson we are about to learn from the taxpayer revolt, as its impact becomes felt in publicly funded health care programs.

REFERENCES

1. Los Angeles County Medical Association: Medi-Cal: Past, present, future. LACMA Physician, Jul 19 1979
2. California Welfare and Institutions Code, Division 9, Part 3, Section 14000
3. Anderson H: Notes Toward a Definition of Performance of Title XIX Programs, and Improvement in That Performance, with Particular Reference to the California Medical Assistant Program (Medi-Cal). Berkeley, California, California Department of Public Health, Dec 1968
4. Zalta E: How we can bring quality medical care to the poor without losing $1-billion a year to fraud and abuse. LACMA Physician, Nov 1, 1979
5. Enthoven AC: Health care costs: Why regulation fails, why competition works, how to get there from here. National Journal, May 26, 1979
6. Leighton RE: Looking for the Monster—Description of the Problem of Medi-Cal Costs and Catalog of Cost Containment Strategies. Sacramento, California Department of Health Services, Jan 1980
7. California's Emerging Prepaid Health Plans. Sacramento, California Department of Health Care Services, Sep 1972
8. Luft HS: How do health maintenance organizations achieve their "savings?" N Engl J Med 298:1336, 1978
9. The Medi-Cal Program, a New Direction. Sacramento, California Department of Health, Fall 1974
10. Babbitt B: Medical Cost Containment Program. Phoenix, State of Arizona, Nov 1979
11. Myers BA: California's Strategy for Cost Containment: The Restructuring of the Medi-Cal Program. Sacramento, California Department of Health Services, Apr 5, 1979
12. Testimony of C. John Tupper, MD, President, California Medical Association: Hearing Before Senate Health and Welfare Committee, Apr 18, 1979